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DESERET HEALTH AND REHAB AT SMITH CENTER LLC	117 W 1ST ST #369 SMITH CENTER, KS 66967

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F 000	INITIAL COMMENTS The following citations represent the findings of the health facility survey for the above named facility. A revised copy of the deficiencies was sent to the provider on 12/10/12.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to assess the need for a potential restraint for 1 of 2 sampled residents with restraints. (#33) Findings included: - The quarterly (MDS) Minimum Data Set 3.0 assessment, dated 10/1/2012, indicated the resident had a (BIMS) Brief Interview for Mental Status of 7, which indicated severe cognitive impairment. The assessment revealed the resident required the assistance of 2 plus staff members for transfers, toileting, and extensive assistance of 1 staff for dressing and personal cares. The MDS revealed no indication of side rail use.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 221	Continued From page 1 The 10/25/2012 care plan, instructed staff to avoid the use of restraints and lacked instruction to staff on the use of side rails. On 11/26/2012 at 2:30 PM, observation revealed the resident used his/her right hand and the half side rail facing the room to reposition him/herself and laid on his/her left side. On 11/27/2012 at 10:00 AM, observation revealed the resident used his/her right hand and the half side rail facing the room to reposition his/herself and laid on his/her left side. On 11/26/2012 at 2:30 PM, Resident #33's spouse indicated that the resident used the half side rail to position him/herself and to help staff with transfers. On 11/28/2012 at 10:00 AM, Nurse H verified that the staff had not assessed the resident for the need for side rails. The facility's policy from Med-Pass, Inc. (revised October 2010) indicated an assessment would be made to determine the resident's symptoms or reason for using side rails. The use of side rails as an assistive device will be addressed in the resident care plan. The facility failed to complete a side rail assessment and failed to address it in the resident care plan for resident #33.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

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F 225	Continued From page 2 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The	F 225		

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sample included 19 residents. Based on observation, interview and record review the facility failed to report an incident of possible mistreatment, neglect or abuse, including injuries of unknown origin, for 2 of the 19 sampled residents. (#8 and #35)

Findings included:

- Resident #8's quarterly (MDS) Minimum Data Set 3.0 assessment dated 10/09/2012, indicated the resident had short and long term memory loss and moderately impaired cognition and decision making skills. The MDS also indicated the resident was totally dependent on the staff for activities of daily living.

The 10/24/2012, facility care plan directed the staff to provide the resident with extensive assistance for his/her (ADL's) Activities of Daily Living and had a risk for falls due to involuntary movements. The care plan directed the staff to teach the resident safety measures, and to use his/her call light when the resident needed assistance. The care plan directed the staff to calm the resident if symptoms of distress developed during decision making and respect the resident's right to make a decision.

On 11/17/2012 at 5:00 PM, nurse's notes indicated staff found the resident lying on his/her stomach on the floor in his/her room. The notes revealed the resident had a small laceration to his/her chin with minimal bleeding, and a bruise on his/her right wrist.

On 11/18/2012 at 7:00 AM, nurse's notes indicated the resident had swelling to the right

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wrist, and discomfort in the wrist with use. The notes indicated the staff notified the family of the fall.

The undated Abuse/Allegation and Reporting policy indicated the following:
1) Report immediately to the Administrator of the facility, State Survey Agencies and Law Enforcement all alleged violations and/or reasonable suspicion of a crime involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property.
2) Alleged violations would be thoroughly investigated, and prevent further potential abuse while the investigation was in process.
3) The investigation results would be reported to the Administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident.
4) If the reasonable suspicion event resulted in serious bodily injury, reported to the State Survey Agencies and Law Enforcement immediately after the suspicion, no later than 2 hours after the event. Otherwise the report must be made no later than 24 hours after forming the suspicion.
5) The facility would promptly ensure the safety of the alleged victim, interview all staff, visitors and residents having knowledge of the alleged abuse immediately to determine validity of allegation. The Administrator or his/her designee would complete the investigation within 5 working days. Document all interviews with the date, time and content of the conversation.
6) Result of the internal investigation would be reported to the Administrator or his/her

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designated representative and to other officials in accordance with state law within 5 working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken. The result of the investigation and the complaint number will be sent to the State Health Department. If faxed, retain a copy of the verification of fax transmittal with the investigation file.
7) If the alleged violation to staff is verified, corrective action up to and including termination would be instituted by the facility. If applicable, notified department of professional licensing of the facility findings and conclusion if the alleged perpetrator is a license nurse, and notify the State Nurse Aide Registry/State Board of licensure of facility findings and conclusion if a Certified Nurses Aide is involved.

On 11/27/2012 at 10:45 AM, observation revealed the resident lying on his/her back on a low bed, with a scoop mattress, and fall mats on the floor.

On 11/28/2012 at 4:20 PM, Nurse B verified the State agency was not notified. Nurse B further verified the State reporting guidelines were reviewed and indicated what they planned to report to the State per data protocol.

The facility failed to immediately report an injury of unknown origin to the State agency. This deficient practice placed the resident at risk for possible abuse and neglect.
- Resident #35's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 9/10/12, revealed the resident had a (BIMS) Brief Interview for Mental

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Status score of 15, which indicated no cognitive impairment. The MDS further indicated the resident required limited staff assistance for bed mobility, was independent for transfers, and received an anticoagulant medication.

The 10/1/12 care plan instructed the staff to handle the resident gently.

The 8/14/12 at 6:04 AM, nurse's notes reported the (CNA) Certified Nursing Assistant noted a large purple area over the resident's left shoulder and down to the left chest when assisting the resident with his/her bath. The area was bruised, appeared light burgundy in color and fading. The resident denied hitting his/her shoulder.

On 11/27/12 at 10:48 AM, observation revealed the resident was seated in his/her motorized scooter in his/her room.

On 11/29/12 at 10:00 AM, Nurse B verified the resident's bruise was from an unknown source and that it had not been reported in accordance with State law.

The facility's Abuse-Allegation and Reporting policy, signed 11/29/12, indicated any bruises, cuts, skin tears, or other injury of unknown origin will be investigated and reported as potential resident abuse. The facility must ensure that all alleged violations and/or reasonable suspicion of a crime involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately to the Administrator of the facility, State Survey Agencies and Law Enforcement.

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F 225	Continued From page 7 The facility failed to report a bruise of unknown origin to the appropriate State agency for Resident #35.	F 225		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. Based on observation and interview, the facility failed to maintain a sanitary, orderly, and comfortable interior for the 32 residents residing in the facility. Findings included: - During the environmental tour on 11/29/12 at 8:00 AM, observation revealed the following: 1) Stained flooring by the recliner in Resident #24's room 2) Gouges and scrapes in the wall around the recliner in Resident #30's room 3) Stained tiles around the base of the toilet in Resident #5's room 4) A brown substance/rust by base of toilet in Resident #17's room 5) Black substance by the base of the toilet in Resident #20's room	F 253		

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F 253	Continued From page 8 6) Chipped or missing linoleum by the door in Resident #9's room 7) The heating/air electrical box/wire exposed in Resident #1's room 8) A brown substance/rust and chipped caulking at the base of the toilet, and a broken kick plate on the resident's door in Resident #55's room 9) Tile missing in the bathroom, stained ceiling tiles, and holes in the closet door in Resident #46's room 10) Stains on the tile on the bathroom floor, rust at the base of the toilet, kick plate loose on the bathroom door, heating/air electric wiring and blue tube loose and exposed, gouged/scraped wall behind recliner in Resident #6's room. 11) No baseboards in the administrative hall and by the east shower room On 11/29/12 at 8:00 AM, Maintenance Staff A verified the above findings. On 11/29/12 at 8:00 AM, Administrative Staff F verified the above environmental concerns. The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for the residents residing in the facility.	F 253		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS	F 257		

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F 257	Continued From page 9 The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 19 residents. Based on observation, record review and interview the facility failed to ensure a comfortable and safe room temperature for 1 sampled resident. (#24) Findings included: - On 11/27/12 at 3:30 PM, observation revealed Resident #24 ambulated with Nurse Aide G to the East shower room where he/she received a shower. On 11/27/12 at 3:53 PM, the resident verified that he/she had received a shower and stated that the room was cold but that "it wasn't too bad as long as he/she stood under the water". On 11/27/12 at 3:57 PM, Nurse B verified the ambient room temperature in the East shower room was 60 degrees Fahrenheit as shown by a thermometer laid on the counter. Nurse B further verified the room was too cold to take a shower in. The facility failed to maintain a comfortable room temperature while providing a shower for Resident #24.	F 257		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 19 residents. Based on observation, record review and interview, the facility failed to ensure resident #27 received necessary services with his/her ADL's (Activities of Daily living) including assistance with meals.

Findings included:

- Resident #27's quarterly MDS (Minimum Data Set) 3.0 assessment, dated 11/15/2012, indicated the resident had short and long term memory loss with moderate impaired decision making skills. The MDS indicated the resident required extensive assistance with bed mobility, transfers, dressing, eating, toilet use, bathing, and personal hygiene.

The 8/28/2012 care plan for ADLs indicated the resident required one staff assistance with transfers, grooming, and dressing. The care plan directed the staff to assist with basic care needs, hydration, snacks, incontinent cares, and position change during periods of restlessness.

On 11/27/2012 at 12:10 PM, observation revealed Resident #27 seated at the dining room table with

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F 312	Continued From page 11 his/her food tray. At 12:23 PM, observation revealed the resident took a spoon full of mashed potatoes and struggled each time to get the spoon up to his/her mouth to eat. At 12:55 PM, observation revealed the resident ate approximately 6 bites of mashed potatoes and his/her chicken fried steak had not been cut up and remained in one whole piece. Nurse Aide J approached the resident to ask if he/she wanted the brownie and the resident stated "no" you eat it. Nurse Aide J wheeled the resident to his/her room and did not attempt to sit and assist the resident with his/her meal. During an interview on 11/27/12 at 1:05 PM, Nurse B verified resident #27 should receive assistance with eating when he/she was in the dining room for his/her meals. The facility failed to provided resident #27 with necessary services to maintain good nutritional status.	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: - Resident #4's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 10/22/12, indicated	F 323		

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the resident had a (BIMS) Brief Interview for Mental Status of 14, which indicated the resident was cognitively intact. The MDS further indicated the resident required total assistance from the staff for all (ADLs) Activities of Daily Living, including bed mobility and transfers.

The 11/1/12 care plan directed the staff to use bilateral bed rails to aide with repositioning, as requested by the resident.

The 10/21/12 side rail assessment revealed the side rails were physician ordered and requested by the resident.

On 11/28/12 at 10:40 AM, observation revealed the resident lying in bed on his/her left side with 1/2 side rails in the up position on each side of the bed. Further observation revealed the side rail on the right side of the bed was loose and when pressure was put on the rail, there was space between the mattress and the side rail.

On 11/29/12 at 9:05 AM, Administrative Nurse B verified the resident's bed had 1/2 side rails on each side of his/her bed. Administrative Nurse B further verified he/she was aware one side rail was loose.

On 11/30/12 at 10:30 AM, Maintenance Staff A verified he/she had been asked to tighten the side rail in the past.

The facility's October 2010 policy, Proper Use of Side Rails, stated when side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space

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may vary, depending on the type of bed and mattress being used.)

The facility failed to provide an environment that is free from accident hazards for Resident #4.

The facility had a census of 32 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents for 1 of 19 sampled residents (#33)

Findings included:

- The quarterly (MDS) Minimum Data Set 3.0 assessment, dated 10/1/12, indicated the resident had a (BIMS) Brief Interview for Mental Status of 7, which indicated severe cognitive impairment. The assessment revealed the resident required extensive assistance of 1 staff member for dressing and hygiene and extensive assistance of 2 plus staff members for transfers.

The 7/28/2012 Smoking Risk report assessment was completed and indicated resident #33 was capable to follow facility safe smoking policy.

The 8/3/2012 care plan instructed staff to explain the facility's smoking policy, location of designated smoking areas, and to remind the resident as needed.

On 11/28/2012 at 7:33 AM, observation revealed the resident dressed, ready for breakfast and waiting on Nurse Aide J to go outside to smoke.

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F 323	Continued From page 14 Nurse Aide J opened the door and resident #33 went outside alone. The CNA Behavior Sheet, dated 11/4/12, revealed that the resident was found smoking in bed at 11:30 PM. The nurse progress notes, dated 11/4/2012 and 11/5/2012, lacked documentation that the resident had been smoking in bed. On 11/29/2012 at 1:15 PM, Nurse B verified that he/she had not completed a smoking risk assessment and he/she failed to document in the nurse progress notes after the resident was found smoking in bed. The facility's Smoking Rules and Policy for residents indicated that the facility provided a smoke free environment for residents, visitors, and staff. Therefore, smoking is prohibited inside of the facility. The facility failed to ensure that the resident environment remained as free of accident hazards as possible and each resident received adequate supervision	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to ensure acceptable nutritional parameters, such as body weight, were maintained for 1 sampled resident. (#30)

Findings included:

- Resident #30's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 10/8/12, revealed the resident had short and long term memory problems and severely impaired decision making abilities. The MDS further indicated the resident required extensive assistance of 1 staff for eating. Continued MDS review indicated the resident had weight loss greater than 5% in the previous month or 10% in the previous 6 months, received a therapeutic diet, and antipsychotic, antianxiety, and antidepressant medications.

The 10/19/12 care plan instructed the staff to encourage the resident to consume a well balanced 2000 calorie American Diabetic Association diet, provide assistance with eating at mealtime snacks between meals, and to follow the Registered Dietician's recommendations. The care plan also instructed the staff to assist the resident with eating and provide a supplemental shake if he/she left 25% or more of his/her meal uneaten.

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The 10/8/12 Mini Nutritional Assessment indicated the resident had a moderate decrease in food intake with a weight loss greater then 6.6. pounds in the past 3 months.

Review of the Registered Dietician's notes revealed the following:

The 8/2/12 Registered Dietician's note indicated the resident was status post a hip fracture in June 2012 and Remeron and Seroquel were added to his/her medication regimen. The resident was receiving multiple supplements due to weight loss after his/her hip fracture but his/her weight was stable at this time. The note also indicated the resident required less assistance with meals at this time. Interventions in place included monitoring weekly weights, meal intake, laboratory results, and if the resident's weight remained stable, greater than 170 pounds, at the next check, then staff was to gradually reduce the additional calories the resident received.

The 10/11/12 Registered Dietician's note indicated the resident continued to receive multiple supplements due to weight loss and his/her weight had continued to decline since his hip fracture even though staff assist him/her at mealtimes. The dietician's note indicated the resident had an unintentional weight loss related to decline in condition as evidenced by: post hip fracture, fluctuating intake but presently better since his/her hospitalization; confusion and agitation; decreasing weight parameters and medication changes. Interventions that were placed at this time included: increased calories at meals using low or no carbohydrate sources, food as desired, weekly weights, monitoring of

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weights, laboratory tests, meal intakes, and preferences.

The 11/1/12 Registered Dietician's note indicated the resident received multiple supplements and would eat seconds at times with breakfast being the meal with the best intake. The note further indicated the resident's gained 5% in 1 week and the staff were to continue the current diet and supplements.

The 11/19/12 Dietary communication note indicated the resident received house supplements with meals and between meals and received 1 1/2 portions of proteins at meals.

Review of the Meal Intake Record revealed the following:

The August 2012 meal intake record revealed the resident ate less than 50% of his/her meal on 2 days at lunch time.

The September 2012 meal intake record revealed the resident ate less than 50% of his/her meal on 5 days at breakfast and 1 day at supper.

The October 2012 meal intake record revealed the resident ate less than 50% of his/her meal on 5 days at breakfast, 8 days for lunch, and 3 days for supper.

The 8/2/12 Pharmacy Consultation Report indicated the Pharmacists recommended re-evaluation of the resident's continued use of Remeron. The Nurse Practitioner responded the resident was having no side effects and the Remeron aided in increasing the resident's

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appetite due to weight loss.

The 9/26/12 Physician's Progress Note indicated the resident had been seen by the nurse practitioner and that his/her weight was stable at 163 pounds.

The 10/5/12 Nurse's note indicated the staff notified the physician of the resident's weight was 159 pounds, down from 163 pounds the previous week. The note further indicated the resident continued to receive house shakes for meals and between meals and remained on Remeron 15 (mg) milligrams, by mouth, every night.

Review of the Resident's Weight Record revealed the following:

6/11/12 - 198 pounds (readmission from the hospital)
7/2/12 - 175 pounds (23# weight loss, 11.6 percent in 3 weeks)
7/16/12 - 168 pounds (30# weight loss, 15.1 percent in 5 weeks)
7/23/12 - 171 pounds
8/2/12 - 172 pounds
8/5/12 - 170 pounds
8/13/12 - 169 pounds
8/22/12 - 168 pounds
9/2/12 - 166 pounds
9/12/12 - 165 pounds
9/16/12 - 163 pounds
9/25/12 - 159 pounds
10/9/12 - 158 pounds
10/16/12 - 166 pounds
10/21/12 - 160 pounds
10/29/12 - 158 pounds
11/5/12 - 154 pounds

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11/11/12 - 152 pounds
11/19/12 - 153 pounds (45 pounds/22.7 percent weight loss in 5 months, weight loss greater than 10 percent in 6 months indicates severe weight loss).

Review of the medical record revealed the last note by the dietician, dated 11/1/12, indicated the resident had the most intake at the breakfast meal and the October weights revealed the resident weighed between 158 - 166 pounds.

Review of the medical record revealed no further assessment or note from the dietician or physician although the resident continued to lose weight weekly from 10/29/12 - 158 pounds to 11/19/12 - 153 pounds. (a continued weight loss of 5 pounds in 21 days or an additional 3.16% weight loss.)

On 11/27/12 at 12:10 PM, observation revealed the resident seated in his/her wheelchair at the dining room table. The staff placed the resident's meal on a tray in front of him/her and he/she made no attempts to pick up silverware or to eat. Nurse Aide BN assisted the resident to eat one bite of his/her meal which consisted of mashed potatoes and gravy, green beans, chicken fried steak and applesauce. At 12:36 PM observation revealed the resident had a fork in his/her right hand attempting to stab the bread with the fork but makes no attempt to pick up the bread. At 12:40 PM observation revealed Nurse Aide J approach the resident and Nurse Aide N indicated he/she had attempted to feed the resident but the resident had refused and he/she had made no further attempts to encourage or assist the resident with his/her meal. Nurse Aide

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J removed the resident from the dining room table and no further attempts were made to encourage or assist the resident to eat his/her meal. At 12:49 PM observation revealed Nurse Aide N propelled the resident him his/her wheelchair to his/her room, attached the call light to the resident's clothes and left the resident alone in his/her room. Observation revealed the staff encouraged or assisted the resident one time and after the resident refused to eat the staff did not prepatent to encourage or assist the resident to eat or offer him/her a supplement as outlined in the plan of care.

On 11/28/12 at 1:35 PM, Nurse Aide T stated that if a resident does not eat well at meals, then the staff try to encourage them, assist them and offer them substitutes. Nurse aide T verified at times the resident eats independently and at other times the staff must assist him/her with the meal.

On 11/28/12 at 2:56 PM, Administrative Nurse H verified the resident has had weight loss and an overall decline in independence in his/her activities of daily living.

On 11/29/12 at 11:39 AM, Nurse S verified the resident received supplements. Nurse S further verified the staff notified the physician's office anytime a resident lost 2 pounds or more.

On 12/3/12 at 11:00 AM, Administrative Nurse B verified the staff assist the resident to eat and if the resident does not eat more than 25% the staff are to provide the resident a nutritional supplement. Administrative B further verified the visiting physicians and practitioners are shown a flowsheet of vital signs, including weights, when

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they make visits.

On 12/3/12 at 4:45 PM, physician office staff R verified the nursing facility staff routinely called or notified the doctors office with any significant weight loss. Office Staff R further verified the resident is seen by rotating physicians when they make rounds at the nursing facility.

On 12/10/12 at 2:15 PM administrative nurse B verified the staff did not document the amount of the nutritional supplement the resident consumed each time it was offered to him/her.

The facility's Weight Monitoring Program Policy, undated, revealed the following:

In the event of a patterned or significant, unintended weight loss of 5 percent in 30 days, 7.5 percent in 90 days, or 10 percent in 180 days, the following interventions will be carried out:
1) Notification of attending physician and family member/responsible party by nursing staff.

The facility's Policy and Process Program for significant weight cahnge diet indicated the facility would provide more food at "best consumed meal" and provide house supplements. The undated Standing Orders for Weight Change indicated if a resident's weight loss is persistent, consider possible physician referral/appetite stimulant.

The facility failed to ensure Resident #30 maintained acceptable nutritional parameters, such as body weight. The facility failed to ensure staff provided encouragement, or assistance at mealtimes, provided substitutes or supplements

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F 325	Continued From page 22 and the record lacked evidence to show the facility reassessed the resident who continued to lose weight.	F 325		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents.The sample included 19 residents. Based on observation, interview, and record review, the facility failed to ensure the residents were free from significant medication errors for 1 sampled resident. (#25) Findings included: - Resident #25's admission (MDS) Minimum Data Set 3.0 assessment, dated 10/10/12, revealed the resident had a (BIMS) Brief Interview for Mental Status score of 7, which indicated moderate cognitive impairment. The MDS further revealed the resident required extensive assistance of 1 staff member for transfers, dressing, and personal hygiene. The 10/10/12 care plan instructed the staff to administer a modified pureed diet with thickened liquids. Although the MDS did not indicate the resident had any chewing or swallowing difficulties. The 10/9/12 physician's order instructed staff to administer Advair Diskus (a respiratory treatment	F 333		

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F 333	Continued From page 23 medication), 1 inhalation, twice a day, to the resident. On 11/27/12 at 8:25 AM, observation revealed Nurse M administered the resident's Advair Diskus to him/her at the breakfast table. Nurse M instructed the resident to swallow the scrambled eggs he/she was eating, then to inhale the medicine when instructed. Further observation revealed that after the resident inhaled the medication, Nurse M informed the resident that he/she could continue eating and Nurse M left the table. The Lexi-Comp Drug Information Handbook for Nursing, 2011, 12th edition, page 622, indicated to rinse the mouth with water after use and spit to reduce the risk of oral candidiasis. On 11/27/12 at 9:22 AM, Nurse B verified the staff were to ensure the resident rinses his/her mouth and spits after administration of the Advair Diskus. The facility failed to ensure Resident # 25 remained free of significant medication errors.	F 333		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by:	F 364		

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The facility had a census of 32 residents. The sample included 19 residents. Based on observation, record review and interview, the facility failed to provide food which was palatable and at the proper temperature for 1 sampled resident who required staff assistance with eating.(#27)

Findings included:

- On 11/26/2012 at 12:00 PM, observation revealed 4 residents seated at the dining room table. Observation revealed a dietary staff delivered the food tray to Resident #27 and placed it in front of him/her and told the resident that his/her lunch was there. Continued observation revealed Resident #27attempted to sit up in his/her chair and eat his/her meal with a fork, dropping food from the fork, before getting the food to his/her mouth. Observation from 12:05 PM to 12:35 PM approximately 30 minutes, revealed the resident repeatedly attempted to eat and was unable to eat a bite of food. At 12:35 PM, Nurse Aide J sat on a chair next to the resident to assist him/her to eat his/her food. The Surveyor requested temperatures be obtained on the resident's food prior to assisting him/her to eat. Dietary Staff K then obtained the food temperatures at the following readings: mashed potatoes and gravy at 80 degrees, and the meatloaf at 83 degrees.

On 11/26/2012 at 12:36 PM Nurse Aide J verified the resident's food had been sitting there for an extended amount of time and was not at an appropriate temperature to serve to the resident. Nurse Aide J stated the staff allowed the resident to attempt to eat independently for 10 to 15

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F 364	Continued From page 25 minutes and if the resident was unsuccessful, staff would provide assistance after that period of time. On 11/26/2012 at 12:39 PM, Nurse B and Dietary Staff C verified the staff should not serve low temperature food to the resident and the food should be re-heated to the proper temperature before serving the resident. The facility failed to provide palative food at the proper temperature for 1 of the residents who reside at the facility.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 19 residents. Based on observation, record review and interview, the facility failed to prepare, store, distribute and serve food under sanitary conditions for the 32 residents residing in the facility who received their meals from the kitchen.	F 371		

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Findings included:

- On 11/26/12, during the noon meal, observation revealed Dietary Staff C working in the kitchen, with his/her hair loose around the nape of the neck, and not covered by his/her hair net. Further observation revealed Dietary Staff K served meals to the residents seated in the dining room, with his/her hair loose at the nape of the neck and on the sides, and not covered by his/her hair net. During the 4 on site days of the survey, there were multiple observations of Dietary Staff C and K with his/her hair loose and not covered by their hair nets.

On 11/28/12 at 8:00 AM, during the breakfast meal, observation revealed Dietary Staff O served meals to the residents seated in the dining room, with his/her hair loose and tucked behind both ears, and not contained by his/her hair net. At 10:45 AM, observation revealed Dietary Staff K prepared the pureed meals with his/her hair loose at the nape of the neck and not covered by his/her hair net.

On 11/28/12 at 10:45 AM, Dietary Staff C verified the staff were to have their hair entirely covered by a hair net.

Review of the facility's Food Preparation and Service Policy, dated December 2010, stated Dietary staff shall wear hair restraints (hair net, beard restraint, etc) so that hair does not contact food.

On 11/28/12 at 11:00 AM, observation revealed 3 covered plastic bins that contained sugar, flour and bread crumbs. The sugar bin had sugar

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spilled on top of the container, the flour bin contained several food crumbs under the lid and on the inside rim of the bin. The bread crumb bin was empty but had crumbs of food on the top. All 3 bins were sticky and greasy. Further observation revealed an electrical outlet/box located on the food preparation table with food crumbs, dust particles and grease on the top and all sides of the box. Observation also revealed a large crack in the floor between the food preparation area and the dishwashing area, several missing floor tiles in front of the dishwasher, several wall tiles missing on the wall below the dishwasher and under the 3 compartment sink. The surface of the kitchen door, which faced the dining room, had dark brown/black areas on it and appeared to be dirty and stained.

On 11/28/12 at 11:05 AM, Dietary Staff C verified the bins that contained sugar, flour and bread crumbs were greasy and dirty, and the electrical outlet on the food preparation table was covered with food crumbs, dust and grease. Dietary Staff C further verified there was a large crack in the floor, tiles missing from the floor and walls, and the surface of the door to the kitchen from the dining room was stained and dirty.

On 11/29/12 at 11:15 AM, observation revealed Dietary Aide Q, dropped the lid of the gallon of milk on the kitchen floor, picked it up, placed it back on the gallon container of milk and placed the milk in the refrigerator.

On 11/28/12 at 11:20 AM, Dietary Staff C verified the milk lid should have been washed before it was placed back on the milk container.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 28 The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 32 residents residing in the facility.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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	175295	A. BUILDING _____ B. WING _____	12/04/2012

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F 431	Continued From page 29	F 431		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents of which 6 were identified as insulin dependent. Based on observation, interview and record review the facility failed to ensure insulin was not outdated for 1 of the 6 insulin dependent diabetic residents (#33) and ensure safe and secure storage of medication.The facility identified 8 cognitively impaired independently mobile residents who reside in the facility.

- On 11/26/2012 at 9:15 AM, during the initial tour, observation revealed 1 insulin flex pen of Novolog, that lacked a name, date when opened, or when the insulin expired. During the observation, Nurse M verified the pen was not labeled with the resident's name or the date when the staff had started to use the flex pen. Nurse M verified the pen belonged to Resident # 33 who recieved the 11/9/12 physician ordered Novolog insulin 30 units subcutaneous before meals up to the current date.

The Lexi-Comp Drug Information Handbook for Nursing 2012, page 756, indicated Novolog Insulin stable up to 28 days.

The 10/2010 facility's multi insulin administration policy indicated the insulin, once opened, would be marked with the expiration date/time, and to follow the manufacturer expiration date.

The facility failed to monitor the resident's

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F 431	Continued From page 30 medication for expired/undated insulin to ensure stability of the medication. - On 11/28/2012 at 10:30 AM, observation revealed on top of the facility medication cart a red plastic storage container with 2 insulin vials and 2 insulin pens and no staff in attendance. Continued observation revealed Resident #33 wheeled his/her wheelchair around the medication cart, impatiently waiting for the nurse to get his/her cigarettes from the medication cart. Observation revealed Nurse I exited a residents room after approximately 8 minutes. The 4/2007 facility's Storage of Medication policy stated the facility shall store all drugs and biological's in a safe, secure,and orderly manner. Continued review indicated "Compartments, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes containing drugs and biological's shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others On 11/28/2011 at 10:45 AM, Nurse I verified the nurses are not to leave the resident's medication on top of the medication cart and unattended by staff. The facility failed to supervise and store medications for the 32 residents that reside in the facility.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 31 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441		

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F 441	Continued From page 32	F 441		

by:
- On 11/28/2012 at 8:30 AM, observation revealed Resident #27 and #28's nasal cannula stored on top of the concentrator in the resident's room. Continued observation revealed staff failed to place the cannula and tubing in a plastic bag while not in use.

On 11/28/2012 8:35 PM, Nurse E verified the nasal cannula and the tubing was not stored properly in a plastic bag when not in use per the facility's policy.

The (10/2010) facility's policy for Oxygen therapy, Infection Control stated, keep the oxygen cannula and tubing used as needed in a plastic bag when not in use.

The facility failed to provide a sanitary environment to prevent the development and transmission of disease and infection for residents in the facility who received oxygen therapy.

The facility had a census of 32 residents. The sample included 19 residents. Based on observation, interview, and record review, the facility failed to ensure proper hand hygiene when providing cares for Resident #21, failed to provide proper disinfection of the glucometer, and failed to provide sanitary storage for oxygen nasal cannulas for 2 of the sampled residents. (#27, #28)

Findings included:

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- Resident #21's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 10/31/12, indicated the resident had short and long term memory problems and severely impaired cognitive abilities. The MDS further revealed the resident required supervision for ambulation in the corridors, was frequently incontinent of bowel and bladder, and required extensive assistance of 1 staff member for toileting and personal hygiene.

The 9/24/12 care plan instructed the staff to provide incontinence care after each incontinent episode.

On 11/28/12 at 7:30 AM, observation revealed Nurse Aide P assisted the resident to his/her room to provide incontinent care. Nurse Aide P applied disposable gloves before removing the resident's wet pajama pants and incontinent brief. He/She then provided pericare to the resident and assisted the resident in applying a clean incontinent brief. Further observation revealed Nurse Aide P continued to wear the soiled disposable gloves while he/she assisted the resident to button his/her shirt, opened the resident's dresser drawer and removed the resident's comb, and combed the resident's hair. Nurse Aide P then opened the resident's door while wearing the soiled gloves, and assisted the resident to ambulate to the hallway.

On 11/28/12 at 2:59 PM, Administrative Nurse H verified the staff were to perform hand hygiene after removing soiled clothing.

The facility's Hand Hygiene Guideline, dated 11/29/12, instructed staff to perform hand hygiene before and after assisting a resident with personal

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F 441	Continued From page 34 care and after handling soiled or used linens. The facility failed to ensure proper hand hygiene when providing cares for Resident #21. - On 11/26/12 at 2:46 PM, observation revealed Nurse M performed a finger stick glucose test on a resident and then cleaned the glucometer with an alcohol swab. On 11/27/12 at 8:05 AM, observation revealed Nurse M used a Clorox wipe (no bleach included) to wipe the outside of the glucometer. Nurse M then performed a finger stick glucometer test on a resident and placed the glucometer in a basket of unused lancets without cleaning it. On 11/26/12 at 2:46 PM, Nurse M verified that he/she used an alcohol swab to wipe the outside of the glucometer and that the facility had non bleach wipes for the staff to use. The Nursing services Policy and Procedure Manual Med-Pass, dated 10/12, instructed staff to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The facility's Cleaning and Disinfecting Instructions for Even Care G2 Blood Glucose Monitor, signed 11/26/12, stated: disinfect your monitor, clean the monitor first using cleaning guidelines, then wipe down the glucometer using a solution of 10% bleach. The facility failed to ensure proper disinfection of the facility's glucometer.	F 441		

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F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. Based on observation, record review and interview the facility failed to ensure the nurse call system worked effectively and efficiently on 2 of the 4 halls and 1 of 3 shower rooms. Findings included: - The 10/2010 facility "Answering of the call light"EK policy stated to: 1) Explain the call light to the new resident. 2) Demonstrate use of the call light. 3) Ask the resident to return the demonstration so that you will be sure that the resident can operate the system. 4) Be sure the call light is plugged in at all times. 5) Some residents may not be able to use the call light so check those residents frequently. 6) Report all defective call lights to the nurse supervisor promptly. 7) Answer the resident's call light as soon as possible. 9) Be courteous in answering the resident's call light. On 11/27/2012 at 8:45 AM, observation on the	F 463		

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F 463	Continued From page 36 South hall revealed Resident #46's bedroom call light failed to signal. Further observation revealed the call light failed to signal at the nurse's station call light system board, above the resident's door and failed to sound. On 11/27/2012 at 3:00 PM, observation on the administrative hall revealed Resident #24 walking down the hall with Nurses Aide G to the shower room. Further observation revealed Nurse Aide G assisted the resident to ambulate to the dining room. On 11/27/2012 at 3:55 PM, observation revealed the East common bathroom call light by the toilet was not working. A sign was posted on the wall next to the call light that stated "this call light does not work until further notice, JB". On 11/28/2012, at 9:04 AM, Maintenance Staff A verified he/she does random room checks on the shower and residents' call light system once a week and staff would notify maintenance when the call light system was not functioning properly. The facility failed to ensure resident #24's room and a shower room had a functioning nurse call light system to notify the staff for assistance when needed.	F 463		